CHAPTER II - CARRIER COVERAGE AND RELATED ISSUES FOR THE AMBULANCE FEE SCHEDULE

OBJECTIVE

The Coverage chapter will provide the medical necessity requirements and coding guidelines for submitting ground and air ambulance services to Medicare.

Suppliers will learn the following in the course of this chapter:

1. Medicare coverage requirements for ambulance services.

2. New aspects of coverage related to the ambulance fee schedule.

COVERAGE REQUIREMENTS

Medicare covers ambulance services that are furnished to a beneficiary whose medical condition is such that other means of transportation would be contraindicated. While physician certification allows the ambulance supplier to assert that transportation was reasonable and necessary, the beneficiary's medical documentation must support the coverage of the transportation.

Effective April 1, 2002, all ambulance suppliers must accept assignment. This means that suppliers cannot bill or collect from the beneficiary any amount other than any unmet Part B deductible and/or Part B coinsurance amounts.

CATEGORIES OF SERVICE

The new ambulance fee schedule has seven categories of ground (land or water) ambulance services and two categories of air ambulance services.

Ground Ambulance Categories of Service

1. **Basic Life Support (BLS)**
2. **BLS-Emergency**
3. **Advanced Life Support 1 (ALS1)**
4. **ALS1-Emergency**
5. **ALS2**
6. **Specialty Care Transport (SCT)**
7. **Paramedic Intercept (PI)**

Basic Life Support (BLS)

Basic life support (BLS) means transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from State to State. For example, only in some States is an EMT-Basic permitted to operate limited equipment on board the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

Basic Life Support – Emergency

The Basic Life Support – Emergency category is the provision of BLS services, as specified above, in the context of an emergency response.

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

Advanced Life Support Level 1 (ALS1)

Advanced life support, level 1 (ALS1) means transportation by ground ambulance vehicle, medically necessary supplies and services and an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

Advanced life support assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

Advanced life support intervention means a procedure that is, in accordance with State and local laws, beyond the scope of authority of an emergency medical technician-basic (EMT-Basic).

Advanced life support personnel means an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications. The EMT-Paramedic is defined as possessing the qualifications of the EMT-Intermediate and also, in accordance with State and local laws, as having enhanced skills that include being able to administer additional interventions and medications.

Advanced Life Support, Level 1 – (ALS1) Emergency

The Advanced Life Support, Level 1 – Emergency Response category is defined as the provision of ALS1 services, as specified above, in the context of an emergency response.

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

Advanced Life Support, Level 2 (ALS2)

The Advanced Life Support, Level 2 category is:

1. The administration of three or more different medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate), **or** (B) transportation, medically necessary supplies and services, and

2. The provision of at least one of the following ALS procedures:
   Manual defibrillation/cardioversion
   Endotracheal intubation
   Central venous line
   Cardiac pacing
   Chest decompression
   Surgical airway
   Intraosseous line.

Specialty Care Transport (SCT)

Specialty care transport is interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training).

Paramedic Intercept

Paramedic intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under limited circumstances, Medicare payment may be made for these services directly to the entity furnishing the PI services. For a description of these circumstances and services see PM B-99-12 dated March 1999 and PM B-00-01 dated January 2000, both titled Paramedic Intercept Provisions of the BBA of 1997.

Air Ambulance Categories of Service

1. **Fixed Wing Air Ambulance (FW)**
2. **Rotary Wing Air Ambulance (RW)**

Fixed Wing Air Ambulance (FW)

The fixed wing air ambulance (airplane) category is services furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (for example, heavy traffic), preclude such rapid delivery to the nearest appropriate facility by ground ambulance.

Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Rotary Wing Air Ambulance (RW)

The rotary wing air ambulance (helicopter) is furnished when the beneficiary’s medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (for example, heavy traffic), preclude such rapid delivery to the nearest appropriate facility by ground ambulance.

Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Physician Certification Statement

Neither the presence nor the absence of the signed physician certification statement necessarily proves (or disproves) whether the transport was medically necessary.

When a non-emergency transport is scheduled or unscheduled, the ambulance supplier must obtain a written order from the patient's attending physician certifying that the medical necessity requirements are met.

Before submitting a claim the ambulance supplier must:

1. Obtain a signed physician certification statement from the attending physician; or

2. If the ambulance supplier is unable to obtain a signed physician certification statement from the attending physician, a signed physician certification must be obtained from either the physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is employed by the attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported and who has personal knowledge of the beneficiary's condition at the time the transport is ordered or the service was furnished; or

3. If the supplier is unable to obtain the required statement as described in 1 and 2 above, within 21 calendar days following the date of service, the ambulance supplier must document its attempts to obtain the physician certification statement and may then submit the claim. Documentation includes but is not limited to signed United States Postal Service forms verifying mail sent to the physician.

The supplier must keep the appropriate documentation on file and, upon request, present it to the carrier. It is important to note that the presence of the signed physician certification statement does not necessarily determine if the transport was medically necessary.

NON-EMERGENCY RESPONSE

Ambulance transportation is covered when it meets medical necessity requirements. Nonemergency transportation by ambulance is appropriate if either: the beneficiary is bed-

confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion, nor a required criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations. For bed confinement, the following criteria must be met:

Bed confinement criteria is met when the beneficiary is:

1. **Unable to get up from bed without assistance**
2. **Unable to ambulate**
3. **Unable to sit in a chair or wheelchair**

1. The beneficiary is unable to get up from bed without assistance;
2. The beneficiary is unable to ambulate; and
3. The beneficiary is unable to sit in a chair or wheelchair.

All three of the above-listed components must be met in order for the patient to meet the requirements of the definition of "bed confined." The term applies to individuals who are unable to tolerate any activity out of bed. This term is not synonymous with "bed rest," "non-ambulatory," or "stretcher-bound."

Non-emergency services may be:

1. **Scheduled, repetitive,**
2. **Scheduled, non-repetitive, or**
3. **Unscheduled**

Some non-emergency services are scheduled. Scheduled may be repetitive or non-repetitive. **Repetitive scheduled** services are regularly provided transportation for the diagnosis or treatment of a patient's medical condition, e.g., transportation for dialysis. Repetitive, scheduled, non-emergency ambulance transports require the ambulance supplier to obtain, before the transport, but no earlier than 60 days prior, a written order from the beneficiary's attending physician certifying that the coverage requirements are met.

Unscheduled services generally pertain to non-emergency transportation for medically necessary services; e.g., from one facility to another.

SPECIAL CIRCUMSTANCES

MULTIPLE PATIENTS

When an ambulance transports more than one patient simultaneously, the payment allowance is based on the number of patients (Medicare and non-Medicare) on board. The mileage payment amount is divided by the number of patients on board.

If two patients were on board, the payment allowance for each Medicare beneficiary is equal to 75 percent of the service payment allowance for the level of care provided to the beneficiary plus 50 percent of the mileage allowance.

If three or more patients were on board for the same transport, the payment allowance is 60 percent of the level of care furnished the patient. The mileage amount is divided by the number of patients (Medicare and non-Medicare) on board.

MULTIPLE ARRIVALS

When multiple units respond to a call for services, only the entity that provides the transport for the beneficiary may be paid by Medicare for all services furnished.

For example, a BLS and ALS ambulance responds to a call. The BLS furnishes the transport after an ALS assessment is furnished. The BLS supplier may bill at the ALS1 rate. Medicare will pay the BLS supplier based on the ALS1 rate. The ALS ambulance company must look to the BLS ambulance company for payment for its services.

PRONOUNCEMENT OF DEATH

Pronouncement of Death

The following information clarifies Medicare policy related to the death of a beneficiary and the payment for any ambulance services.

The death of a patient is recognized when the pronouncement of death is made by an individual legally authorized to do so by the State where the pronouncement is made. The following three scenarios apply to payment for ambulance services when the beneficiary dies before a ground or air ambulance arrives.

1. If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment based on the base rate may be

made. However, neither mileage nor a rural adjustment would be paid.

Payment is made based on the BLS level of service if a ground vehicle is dispatched.

If an air ambulance is dispatched, payment is made based on the fixed wing or rotary wing base rate, as appropriate.

2. The beneficiary is pronounced dead after being loaded into the ambulance, regardless of whether the pronouncement is made during or subsequent to the transport. A determination of "dead on arrival" (DOA) is made at the facility to which the beneficiary is transported.

   Payment is made following the usual rules of payment (as if the beneficiary had not died).

3. No payment will be made if the beneficiary was pronounced dead prior to the time the ambulance is called or dispatched.

HCPCS CODES FOR AMBULANCE SERVICES

The following codes are used to reflect the service rendered and the type of vehicle used.

The following HCPCS codes are effective for dates of service on or after January 1, 2001:

A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)

A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air service, transport, one way (rotary wing)
A0432	Paramedic Intercept, rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers (PI-volunteer ambulance co)
A0433	Advanced life support, level 2 (ALS2)
A0434	Specialty Care Transport (SCT)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
Q3019	Ambulance service, Advance Life Support (ALS) Vehicle used, emergency transport, no ALS level service furnished
Q3020	Ambulance service, Advance Life Support (ALS) vehicle used, non-emergency transport, no ALS level service furnished

RETENTION OF LEVEL III HCPCS CODES

You may continue the use of Level III HCPCS codes (this system was in effect on August 16, 2000) through December 31, 2003. This is required by BIPA §532, enacted December 21, 2000. You may not use a Level III code if there is a Level II code that is appropriate.